**Application for CCG Funding**

Date:

*Please ensure the Patient’s name is represented by their initials only*

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| **PATIENT INFORMATION**  |
| **Type of request:**  | **NEW CONTINUED ADDITIONAL** |
| **Rio Number:**  |  |
| **Year of Birth:**  |  |
| **Age:**  |  |
| **GP Name & Location:** |  |
| Does the person have capacity to make their own decision relating to this service? If so has written consent been obtained?  | YES / NOYES / NO |
| If not has a formal MCA been recorded and how have you arrived at this decision? (details of best interest decision, role of advocate & IMCA) |  |
| Is the individual subject to S117 aftercare?If yes, please confirm Section & Date: |  YES / NOSection: Date:  |
| Mental Health Diagnosis:  |  |
| Presenting Physical issues: |  |
| Presenting Mental Health issues:  |  |
| **PROPOSER***(Please identify the team and details of the staff member submitting this funding application).* |
| Team:  |  |
| Person submitting application: |  |
| Position: |  |
| Date: |  |
| **CURRENT CIRCUMSTANCES** *(Please explain in full)*  |
| What are the current circumstances of the person? |  |
| Is the individual in receipt of any existing care plan or package of care? If so, please give details: |  |
| Have all local options been provided / attempted? **Please give full details of relevant/recent treatment and interventions provided locally (to date) and their outcomes.** |  |
| **RISKS** |
|  |
| **PROPOSED SUPPORT ARRANGEMENTS**  |
| **SUPPORT** - What is being requested? (details of service/support).  |   |
| **PLAN** - Support Plan (day of week - am/pm/ night time etc.) with crisis management (support in place/what will happen if support is not available?) |  |
| **WHY** - Reason for request? |  |
| **OPTIONS** - What other services have been considered? |  |
| **PROVIDERS** - Providers considered, preferred provider, reasons and Care Funding Calculator comparison made |  |
| **INVOLVEMENT** - How has the individual/family been involved in this decision? (include best interest decision making or use of advocate & preferences noted). |  |
| **OUTCOMES** - What outcomes will this service/ support package deliver to the individual? (include over what period of time and the review process) |  |
| **DIVERSITY** - Have the individual’s cultural needs been considered? If so, how they will be met by proposed intervention/ provider? |  |
| **SAFETY** - CQC report & safeguarding checks completed? |  |
| **FINANCIAL INFORMATION**  |
| Cost details: Current and/or proposed (per week) |  |
| Is this a Joint or Sole application to Health? If Joint please confirm **%** split proposed:Has LA funding application been submitted / approved? | YES / NO |
| **Clinical Information**  |
| Is this application supported by the Clinical team involved in the patients care? Care Co-ordinator/Clinical Lead, Consultant Psychiatrist | YES / NO |

Signed: Date:

Care Co-ordinator /

Person completing form: Date:

Consultant Psychiatrist: Date:

Locality Manager: Date:

East Panel

Representative: Date: